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ABSTRACT

Providing mental health services to children and youth has long been a tremendous challenge for communities. Numerous reports and studies demonstrate that children in Minnesota and across the nation struggle with a variety of unmet mental health needs. As a result, children are placed at great risk for failure in education, in the work force, and in their relationships with others. This paper was written in an effort to help educators and education policymakers understand how and why schools are a key component of any comprehensive mental health service system. The paper has five purposes: (1) to provide a brief history of mental health services provided in educational contexts; (2) to examine the definitions of key terms used in the provision of education-related mental health services; (3) to describe laws and policies related to the provision of mental health services in schools; (4) to discuss child development issues related to mental health services in educational contexts; and (5) to offer a set of recommendations to guide policy development in children's mental health. (Contains 47 references.) (MKA)

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FROM COMPASS TO ROAD MAP:

Developing Comprehensive Policy for Delivering Mental Health Services in Schools

National Association of School Psychologists
Annual National Convention
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Perspectives on Policy for the Provision of Mental Health Services in Schools

Prepared for:

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Preface

Perspectives on Policy for the Provision of Mental Health Services in Schools was prepared by Susan Moses-Zirkes, University of Minnesota, Christine M. Hurley, University of Minnesota and Gordon D. Wrobel, MN. Department of Children, Families and Learning. The project was funded by the MN. Department of Children, Families and Learning, Division of Special Education using federal discretionary dollars.

The paper was written in an effort to help educators and education policy makers understand how and why schools are a key component of any comprehensive mental health service system.

Executive Summary

Providing mental health services to children and youth has long been a tremendous challenge for communities. Numerous reports and studies demonstrate that children in Minnesota and across the nation struggle with a variety of unmet mental health needs. As a result, children are placed at great risk for failure in education, in the work force and in their relationships with others.

This paper was written in an effort to help educators and education policy makers understand how and why schools are a key component of any comprehensive mental health service system. This paper has five purposes:

- to provide a brief history of mental health services provided in educational contexts;
- to examine the definitions of key terms used in the provision of education-related mental health services;
- to describe laws and policies related to the provision of mental health services in schools;
- to discuss child development issues related to mental health services in educational contexts; and
- to offer a set of recommendations to guide policy development in children's mental health.

A large body of literature consistently demonstrates that children and youth have many mental health needs that are unmet by the current systems that provide mental health services. Recognizing that mental health, social development and educational success are inextricably linked, schools have historically provided a variety of formal and informal mental health services to children and youth. Efforts to provide these services have varied widely in scope and rigor. In some schools, such services are nonexistent; in school systems providing mental health services the services span a spectrum from simple screening, minimal intervention and referral, to programs that are both comprehensive and inclusive of the child, family and community.

The active involvement of schools in mental health services stems from a variety of influences. These include, but are not limited to, shifts in societal attitudes concerning mental health, federal and state mandates, and locally pressing need for services. However, education's role in the provision of mental health services has evolved largely in the absence of comprehensive policies regarding mental health. The vast majority of the mental health effort in education is relegated to informal organizational structures that are not supported by formal policy. This has resulted in a system of services that is poorly articulated, has little formal accounting of

expenditures, and is without the benefit of outcome data upon which to base programmatic or policy decisions.

The lack of comprehensive policy presents substantial problems for educators and subsequently for children and families. Without policies encouraging formal programs and collaboration among service providers, services have become fragmented, reactive and often inaccessible to the consumers who need them. In such an atmosphere, it has been difficult for educators and mental health professionals to determine when, how and by whom a particular mental health service should be offered to a particular child. When services are delivered, it is equally difficult to establish accountability and to assure continuity.

President George Bush often referred to "points of light" when describing the many promising efforts to improve life for the citizens of this country. Efforts to provide mental health services to children and youth have provided little beyond flashes of light; all too often such efforts have not been sustainable for a host of economic and political reasons. Current efforts to promote systems change through interagency service structures show great promise. However, children's mental health services have received only modest attention and financial support from policy makers at the state and local level. In many respects, it is a shameful picture that has been portrayed by report after report on the state of our children's mental health service system.

To remedy this situation, the concerted efforts of policy makers at all levels of government will be needed. This will likely be an expensive endeavor, yet we must come to clearly understand the very real costs of not attending to the mental health needs of our children and youth. Systems change in an environment of shrinking resources will be difficult at best. Yet, our children's mental health needs will not be denied their due.

The following set of recommendations represent a distillation of the literature reviewed here and the thoughts of the authors. These points are offered as considerations in the development of policy and practice in addressing, in educational contexts, the mental health needs of our children and youth.

- There currently exist efficient and effective models for the delivery of children's mental health services, including school-linked, school-based and full service schools.
- All state departments entrusted with programs affecting children need to have available, as a formal part of the organizational structure, persons and programs that can competently address policy concerns regarding children's mental health.
- State departments and local service system providers must develop strong policy that is respectful of families and clearly defines the roles and responsibilities of the service system. The education community

must develop state and local policy that clearly defines mental health services in a manner consistent with existing law.

- Champions of children's mental health need to be identified and supported in state and local education policy arenas. Expertise in mental health promotion and intervention must continue to be developed and utilized in the development of policy.
- Substantial training is needed to raise awareness of the importance of mental health. A public relations campaign must be mounted to confront the stigma of mental illness and the resulting discrimination. Staff working in state and local education systems need access to ongoing training opportunities to assure that interventions, programs and policies support healthy emotional development for all children.
- Funding for education and other mental health services must be dramatically increased if communities are to be afforded a reasonable opportunity to overcome the mental health challenges children face.
- The mechanisms for funding services must be simplified and made public so that programmatic decisions can be based on data from the total system of care. Programmatic decisions must be fiscally responsible to the total system of care and be independent of simple cost-shifting between members of the service system.
- Families must be assured of their right to direct the care of their children. Policies and the resultant services must be sensitive to the diversity within a particular community.
- Approaches to the provision of mental health services must be comprehensive and involve the total community. Education must be a full partner in any community effort.

Introduction

Providing mental health services to children and youth has long been, and continues to be, a tremendous challenge for communities. Numerous reports and studies demonstrate that children in Minnesota and across the nation struggle with a variety of unmet mental health needs, such as depression, substance abuse, and attention and behavioral disorders. While mental health services exist in most communities, they tend to be fragmented and are often inaccessible to those who need them most. As a result, children are placed at great risk for failure in education, in the work force and in their relationships with other people.

In response to these problems, state and local policies are currently being created which support the coordinated delivery of mental-health, educational and related services. However, some of the same barriers that obstruct service delivery also make policy development and implementation difficult. These barriers include a general lack of knowledge about the separate perspectives of various service providers, and a long history of service development based on categorical funding - rather than collaboration - among educational, social service, corrections, health and mental health systems. As these communities struggle to develop policies that change the way the mental health service system does business, ever increasing numbers of children go without essential mental health services. There is a necessary tension between the emerging service system and those children and families who simply cannot wait until tomorrow for the services they require.

Minnesota is currently engaged in an initiative to increase collaboration in mental health service delivery for children. State policy has embraced a philosophy of formal collaboration that encourages cooperative efforts across agencies in communities and at the state level. The state has also made a commitment to include children and families as partners in policy development and in the design of mental health programs and services. The vision which has been adopted is one of a consumer-driven system that is accountable for achieving consumer outcomes.

The purpose of this paper is to assist policy makers and program developers in their efforts to create an effective service-delivery system. The authors' intention is to offer the audience an overview of the connections among education, mental health and mental health services. We believe that understanding these connections will help to underscore the need for interdisciplinary cooperation, and provide professionals with the critical background information needed to engage in the collaborative process.

This paper focuses on the education system, in order to help educators and other professionals understand how and why schools are a key component of comprehensive mental health service systems. The paper is organized into four major sections. The first section summarizes definitions of mental health and mental health services. It then explores changing conceptualizations of schooling and childhood as social factors prompting schools to provide mental health services. The second section describes

children's mental health needs and the current state of mental health service delivery. The third section outlines federal legislation and state mandates as forces shaping schools' involvement in this field. Finally, the paper offers a set of recommendations for policy development in this area.

It is beyond the scope of this paper to provide an exhaustive discussion of education's contribution to the provision of mental health services. An extensive reference list is included for readers who wish to pursue such information. This paper, rather, will provide a snapshot of how the current system evolved, in order to assist policy designers in reforming systems.

Historical Overview

Definitions of mental health.

Mental health is sometimes thought of as merely the absence of mental illness. But more comprehensive definitions emphasize psychological strengths, as well. One typical definition is that mental health is "a relatively enduring state of adjustment in which people have feelings of well-being, are realizing their abilities, and coping with everyday demands without excessive stress" (Houston, 1995).

Some authors (Seeman, 1989, cited in Heflinger, 1992) note that mental health is best viewed as a two-dimensional concept. One dimension consists of a continuum between illness and the absence of illness; the other dimension consists of a range of adaptive thoughts, feelings and behaviors. This definition is useful for educational contexts because it allows one to speculate about two kinds of prerequisites for children's healthy functioning and successful school performance. Promoting healthy development entails preventing psychopathology and fostering psychological competence.

When considering child mental health, it is critical to keep in mind a developmental perspective (Sroufe & Rutter, 1984). Educators, families and mental-health professionals are concerned not only with how children are functioning at a particular moment in time. They also want children to grow in ways that lead to positive outcomes in the future. However, ensuring healthy development is a complex and challenging task, because development is shaped by the interactions of many different factors. In the risk and resilience model of child development (Masten & Garmezy, 1985) these many factors are labeled as either risk factors (those which are associated with psychosocial disorder) or protective factors (those associated with resilience to stress). The accumulation of risk and protective factors is different for each child, and factors interact differently to shape healthy or unhealthy development.

For example, two children might be born under similar circumstances - both born prematurely to mothers who abuse alcohol. Both infants would likely be difficult to care for and have poor initial relationships with their mothers. However, suppose that one of the mothers completes substance abuse treatment, reunites with her family, finds steady employment and

learns to care for and interact with her toddler. Despite initial risks, this child enters school ready to learn, encounters nurturing teachers, finds success in the early grades and proceeds smoothly through subsequent developmental phases. The other mother does not find the same supports, and has continued difficulty providing an enriching environment to her toddler. This child begins school with classroom behavior problems in kindergarten, which are followed by problems getting along with teachers and peers and difficulty learning to read. As this child develops, a "snowball" effect places him at serious risk of acquiring a "label" that reflects educational and mental-health problems, such as "conduct disorder," "learning disability" or "emotional/behavioral disorder."

Definitions of mental health services.

Traditional definitions of mental health services typically focus on where the service is provided, and the credentials of the person providing it. One such definition is: "outpatient or inpatient-residential care offered by mental health professionals" (Rog, 1992). Definitions of mental-health professionals vary from state to state, as defined by licensure laws. Recently, definitions of mental health services have broadened. Mental health services now include both primary and secondary prevention services, as well as treatment, and services are provided in a wide range of settings by a wide range of professionals. These settings include education, community health, medical, juvenile justice, and social welfare settings. Services are provided by educators, physicians, nurses and non-clinical community workers, as well as psychiatrists, psychologists, counselors, and others more typically thought of as mental health professionals.

Summarizing these points, Rog (1992) defines a mental health service as "any service that is intended to identify, diagnose or treat an emotional, behavioral, or learning disorder in a child or adolescent independently of sector, provider type, and source of payment" (p. 19). One way to illustrate the breadth of Rog's definition is to picture a continuum of services, with purely educational services at one end, child mental health services in the middle, and child medical services at the other end. Clearly, Rog's definition encompasses all of what is traditionally known as mental health services, as well as significant components of educational and medical services.

Role and function of schools.

Schools became involved in the provision of mental health and other non-academic services to students as a result of changing visions of the role and function of public schools. These changes have been well described in reviews by Bricklin et al. (1995) and Tyack (1992) and will be summarized here.

Historically, three distinct conceptualizations of purpose, or visions, have shaped the structures and practices of public schools in the United States (Schlechty, 1990, cited in Bricklin et al., 1995). The first of these visions defined schools as tribal centers, and was prevalent in early Colonial

America. The primary purpose of schools as tribal centers was to promote morality, literacy, and socialization into the dominant culture (Schlechty, 1990). Educational laws mandated that children learn to read and write but did not require school attendance; thus, many children still learned at home. Bricklin et al. (1995) assert that during this time period, child health was not an important consideration for schools for two reasons. First, schools and communities were so closely linked that health needs were addressed within those two systems. Second, the quality of professional health services was generally poor and services were not available to all communities.

Both the second and third visions of schools - schools as factories, and later as hospitals - emerged as a result of the industrial revolution in the United States. During this time, the purpose of American education shifted away from the promotion of a common culture toward the production of uniform products (students) to work in an industrial society. Still, health services were not an integral part of the educational system (Bricklin et al., 1995; Schlechty, 1990). Tracking and the graded school system were introduced as ways to assure the production of uniform workers.

Schlechty (1990) notes that the vision of schools as factories also introduced an unanticipated outcome - school failure - into the public schools. The federal compulsory school attendance law was passed in 1852 and while the law's original intent was to serve the purpose of uniform production, heterogeneity rapidly became the norm as immigrant children from a variety of different cultural backgrounds began to attend school (Bricklin et al. 1995). This new concept of school failure, combined with mandatory attendance laws and the challenges associated with serving a heterogeneous student body all combined to give rise to the third vision of schools, schools as hospitals.

The vision of schools as hospitals arose in response to the numerous health and social concerns that accompanied industrialization (Bricklin et al., 1995). This vision marked societal recognition of the link between health and educational outcomes, and subsequently, schools' entry into the provision of mental health services. The impetus for the provision of health and social services in schools originated from outside of schools by community members, public health doctors and women's clubs which had become interested in the welfare of the urban poor, particularly children (Bricklin et al.; Tyack, 1992). During this time, the purpose of schools shifted from the production of uniform workers to the amelioration of "the pain and suffering imposed on children by society" (Bricklin et al., p. 15). In his description of schools as hospitals, Schlechty (1990) contends that "the growth and development of the individual child were the prime values to be served by schools" (p. 6). As a result of formal collaborative and coordinated relationships with physicians, community agencies and child advocate volunteers, schools expanded their service delivery to address students' social and medical issues by providing health screenings through visiting physicians and dentists as well as tuberculosis testing and psychological evaluations (Bricklin et al.). School nurses broadened the scope of services to

include home visits and truancy issues (Fagan, 1992, cited in Bricklin et al.). Free and inexpensive meals, playgrounds, visiting teachers, and vocational counseling services also became available to students as a result of these collaborative ventures (Tyack, 1992). According to Bricklin et al., "public schools came to be viewed as the one place where medical, welfare, psychological and educational services could be provided to large numbers of children" (p.15).

In the early 1900s, schools began to incorporate health and mental health services by hiring their own service providers (Tyack, 1992). Not surprisingly, the professions of school psychology, school guidance, and school social work all evolved during this time. Professionals in these roles provided community outreach, linkages between home and school, counseling services to distressed children, as well as services for individual children who were struggling with school work (Bricklin et al., 1995; Sedlack, 1981; Tyack, 1992).

The institutionalization of school health services from the 1920s to the 1950s shifted the target population from primarily immigrant and poor children and their families to all children. However, the end result was that resources shifted from those who needed them most to those schools and communities that could afford to maintain social and mental health services during difficult economic times (Tyack, 1992). Bricklin et al. (1995) state that during this time period, the label of "pupil services" evolved to describe the many non-academic services that were being provided to students. Based on the belief that "instruction can not be entirely effective without supporting programs that alleviate both in-school and societal factors" (Bricklin et al., p. 17), pupil services typically included counseling and guidance, psychological services, social work, speech and hearing, and special education.

During the 1960s and 70s, reformers once again focused their efforts on "disadvantaged populations," including not only poor children and families but also people of color and persons with disabilities (Tyack, 1992). Characterized by intense social activism, this era saw the passage of federal legislation that provided supportive services to children and their families including Headstart and Title I programs, Community Mental Health Centers and the Education of All Handicapped Children Act (P.L. 94-142). According to Bricklin et al. (1995), special education became linked to pupil services when P.L. 94-142 was passed and became "a formal vehicle for the delivery of psychological and health services within the schools" (p. 19).

Unlike the 1960s and early 70s, the late 70s and early 1980s were characterized by increased attention to academic standards and economic competitiveness - a "back-to-basics ideology" (Tyack, 1992). Despite this change in focus, Tyack notes that schools were increasingly becoming multipurpose agencies, as evidenced by the rising percentages of school personnel who were not educators. In 1950, 70% of all school employees were teachers; by 1986, only 52% of all school employees were teachers. Similarly, Bricklin et al. (1995) conclude that while "neither schools nor the public has wholeheartedly accepted the vision of "schools as hospitals", the range of

services provided by school districts has clearly expanded beyond basic academics. Although staffing configurations and service delivery packages differ markedly across school districts, schools have come to offer an array of health and social services under the rubric of pupil services" (p. 19).

Evolving views of children

Changes in the roles and functions of schools reflected not only the changing nature of societal structures but also evolving viewpoints about children and their role in society. In the pre-industrial United States, children were an integral part of family life particularly in terms of economic utility on family farms. Most education was provided by family members or others in the community; formal schooling was rare but for the very wealthy. The rise of industrialization brought about important changes for children's education and development, beginning with the passage of mandatory school attendance laws.

Initially, school attendance laws had little effect on actual attendance. Children and youth continued to work on family farms and in 1900, several decades after the passage of the compulsory attendance laws, only 4 percent of American youth were graduating from high school (Nichols & Nichols, 1990). As the United States grew into an increasingly industrial society, it became clear that more and more children would eventually work in settings that were outside their parents' realm of knowledge. Recognizing that the way for children to be successful was through school, parents began to invest more in children's preparation and attendance at school. According to LeVine and White (1992), "mass schooling established in a public and unavoidable way that childhood was dedicated to preparation for adult roles outside the family" (p. 306). This view of schools still exists today and in fact, the consequences of not finishing school have increased tremendously. Viable employment opportunities are scarce for individuals without a high school diploma (Evelo, Sinclair, Hurley, Christenson, & Thurlow, 1996).

In addition to changing views of childhood preparation for later life, the industrial revolution transformed the way children themselves and parent-child relationships were conceptualized. Whereas agrarian views of childhood identity revolved around family and were characterized by obedience and reciprocity, emerging theories of child development emphasized childhood as a distinct, and valuable phase of life (LeVine & White, 1992). Concurrent with the vision of schools as hospitals, "a new emphasis was placed on the protection and nurturance of children accompanied by a sense of hope regarding their impact on the future of society" (cited in Bricklin et al., 1995, p. 15). This evolving perspective of children, emphasizing well being and healthy development, can be thought of as another factor that influenced the integration of mental health services into schools. In addition, while the perception of parents' roles as nurturers of their children has persisted through to modern day, there is a considerable body of evidence to suggest that today's children in schools face a host of

challenges and problems that are beyond the scope of parents alone to overcome.

In summary, perspectives on children and childhood have changed dramatically since the turn of the century. Whereas early views of childhood emphasized loyalty, obedience and parents as the overwhelming influence on child development, today childhood is accepted as a distinct developmental phase and we recognize that developmental outcomes are the result of a multitude of influences and interactions.

Current Status of Children and Mental Health Services

While historical conceptualizations of children help us understand why it was that schools first became involved in the provision of mental health and supportive services, a review of the literature highlights the current, urgent need for ongoing intervention and service. It also sheds light on the question of why schools continue to provide services to children and youth in the absence of formal mandates or policies.

Consideration of the question "What does it take for a child to be a learner?" provides a jumping-off point for understanding why schools persist in providing mental health and other supportive services. Very little has been written about this topic and what has been published seems to focus on what services are provided and how rather than on what children need to be learners and how supportive services are affecting those outcomes (GAO, 1993).

One exception to this is the construct of "readiness to learn." In considering this concept, researchers have identified six key dimensions of school readiness: physical well being; social confidence; emotional maturity; language richness; general knowledge; and moral awareness (The Carnegie Foundation for the Advancement of Teaching, 1991, p. 7). The significance of readiness to learn for education is reflected in National Goal #1, which states that "By the year 2000, all children will start school ready to learn" (National Education Goals Panel, 1993). Sadly, the results of research focusing on readiness to learn suggest that achieving Goal #1 by the year 2000 is all but impossible. For example, the Carnegie Foundation reported the results of a study conducted by the Southern Regional Education Board in which they predicted that nearly one-third of the estimated one million children projected to be entering first grade (in that part of the country) will not be prepared to do so in the year 2000 - unless additional steps are taken now. The following review highlights the fact that not only are students entering school not ready to learn, but a significant number of students have mental health problems that interfere with their ability to learn once they are in school.

Children's mental health.

It is commonly estimated that 12-15 percent of children have mental health problems that need treatment, yet only 3 percent of children receive

mental health services in their communities (Bricklin et al., 1995). Other studies have found rates of risk for psychiatric disturbance as high as 38.5 percent, among a sample of over 800, 6 to 11-year-olds in a Northeastern city (Zahner, Pawelkiewicz, DeFrancesco & Adnopol, 1992). Measures of student self-esteem also serve as indicators of children's needs. For example, Kramer (1992) asserts that child and youth reports of self-esteem decrease dramatically from the time children enter school to graduation. The National Commission on the Role of School and the Community in Improving Adolescent Health (1990) reports that since 1968, the suicide rate has doubled for teenagers, making it the second leading cause of death among adolescents. In addition, more than one million adolescents in the United States get pregnant each year; a rate that is more than two times as high as any other industrialized country, and more than 2 million children and youth are reported abused or neglected (National Commission on the Role of School and the Community in Improving Adolescent Health, 1990).

The impact of mental health problems on children's performance in school is significant. For example, depending upon measurement strategies, estimates of dropout rates for students receiving special education services for an emotional or behavioral disorder (EBD) are as high as 55 percent compared to the national average of 12 percent (National Center for Education Statistics, 1993). In addition, students with EBD generally earn lower grades, fail more courses, and are more often retained than any other group of students (Koyanagi & Gaines, 1993). Similar results have been found for students in regular education. Research suggests that students who suffer from depression, attend school under the influence of substances, or worry about other issues such as increasing violence or unprotected sexual activity are less able to benefit from teacher instruction (Talley, Short, & Kolbe, 1995), are absent more often from school, fail more classes and are more likely to drop out (Chervin & Northrop, 1994). It has also been shown that childhood conduct disorders and other externalizing disorders are among the most stable of all mental health disorders (Kazdin, 1987a; Kolko, 1994). While other disorders often remit with maturation, childhood antisocial disorders tend to be enduring, intensify over time without treatment, and become more resistant to change with age (Kazdin, 1987b; Robins, 1981).

A related issue is that of teacher training. In a study conducted in 1972, Ryker and Vierkant (cited in Grossman, 1979) found that teachers believed they had inadequate training to cope with mental health issues, that they lacked supportive services from the school system, and that they would welcome collaboration with mental health professionals. Teacher training in the area of mental health continues to be an important issue for schools, particularly for those schools where students are confronted by multiple challenges (Greenspan, Seeley, & Niemeyer, 1994).

It is clear that children and youth in American schools, both in special and regular education, are confronted with numerous and complex issues such as poverty, HIV/AIDS, and substance use that impact not only

educational outcomes but also their emotional and social development. At the heart of most of these issues are mental health concerns.

Mental health provision in schools.

In the absence of comprehensive policies regarding the provision of mental health services for students, it is difficult to know just how to evaluate services. A review of journal articles and book chapters, relevant research, conference proceedings and government and community agency documents suggests that in fact, many schools are providing a variety of mental health services to students in both special and regular education. Often, these efforts are not labeled as mental health services, for a host of reasons. Professional, political and practical pressures may encourage practitioners to label these efforts as something other than targeted mental health interventions (State of Minnesota, 1992).

One significant indicator of the importance of this topic to researchers, school personnel, mental health practitioners, policy makers, parents, and students alike is the quantity of written documents, committees, working groups, and emerging national centers that have been organized around the issue of mental health services in schools. For example, parents have repeatedly expressed interest in comprehensive school health programs and mental health services through surveys and polls (Igoe & Duncan, 1996; APA testimony, 1995), even for traditionally controversial services such as sexuality education. Youth advisors (ages 10 to 19) to the Office of Technology Assessment's (OTA) document on adolescent health (Dougherty, 1993) helped define several major policy options to improve the quality of adolescent health care. Their primary recommendation was to increase access to school (or community) - based services. At the school level, two separate surveys of school principals in New York City (Greenspan, Seeley, & Niemeyer, 1994) and Minnesota (Wahlstrom & Wrobel, 1996) found that principals perceived services to address children's mental health needs as critically important and increasingly necessary, both for children with and without identified disabilities. More formal mechanisms for discussion and research have included the Child and Adolescent Service System Program (CASSP), the American Psychological Association's (APA) working group on schools as health services delivery sites (Bricklin et al., 1995), the Center for Mental Health in Schools at UCLA, the National Research Council's Commission on Behavioral and Social Sciences and Education (1993), the working group of the Education Development Center and Bellsouth Foundation (Chervin & Northrop, 1994), the Packard Foundation and the National Commission on the Role of School and the Community in Improving Adolescent Health (1990). Many of these groups, plus a number of other researchers, have published papers or produced documents relating to various facets of the provision of mental health services in schools (e.g., Adelman & Taylor, 1993; Allensworth & Kolbe, 1987; Talley et al., 1995; Tharinger, 1995). These efforts stand as a testimony that schools not only recognize the need to address these issues but are also actively involved in the provision of mental health

services. Overall, they point to the importance of addressing students' mental health needs and suggest the inextricable intertwining of education and health (Allensworth & Kolbe, 1987).

It should be noted that consensus does not exist in this country regarding the provision of mental health services to children in schools. In fact, there are vocal critics against schools' involvement in this domain (e.g., National School Boards Association, 1996). Arguments against involving schools in mental health services include concerns about patient confidentiality, quality control, provision of services by non-certified professionals, religious beliefs and practices, as well as convictions that schools' roles and responsibilities should be tightly focused on "the three R's" (Tyack, 1992; Yell, 1996). Other arguments reflect fiscal concerns pertaining to health-related services such as psychological counseling or other "noneducational support services" (National School Boards Association, 1996; Pile et al., 1995). Conflicting values and belief systems regarding issues such as sexuality education and birth control also contribute to critical views of school services (Parents, Schools and Values, 1995).

As previously stated, many schools are already providing some form of mental health services to children and youth. With few policies at the state and local levels to guide program development, health and mental health service provision has been driven primarily by school officials and community residents in response to local needs (Dryfoos, 1995; Igoe & Duncan, 1996). In terms of numbers and types of services provided, surveys of 50 states by the Robert Wood Johnson Foundation's Making the Grade Project suggest that in the last two years, the number of school-based health centers (SBHC) nationwide has more than doubled (cited in Children's Defense Fund, 1995). In 41 states, the total number of SBHCs is estimated to be approximately 600. A major reason for this progress is that states have, largely on their own initiative, more than doubled their own investments in centers (Children's Defense Fund, 1995). In her article on state-of-the-art mental health services for children at the end of the 1980s, Tuma (1989) reports Dougherty, Saxe, Cross, & Silverman's (1987) finding that in 1984, 4 million students (ages 3-21) received mental health services under P.L. 94-142. However, she did not specify what types of services were provided.

Current measures of spending and service delivery are difficult to obtain for two reasons. First, there is significant variability across school districts, cities, and states in terms of service provision and second, the lack of comprehensive policies regarding the definition, provision and accounting of mental health services in schools prohibits the collection of accurate data. For example, in a report prepared for the Department of Children, Families and Learning in Minnesota, Baker (1996) conducted a comprehensive review of the literature aimed at identifying finance models for assessing the cost of mental health services in the schools. She did not find any models with this particular focus and noted that "despite the fact that schools have substantial costs related to the mental health of their students, major cost studies have

confined their investigations to clearly identified special education programs and services" (p. 28).

Igoe and Duncan (1996) reported the findings of several national investigations of school health services in their paper on components of school health care. Results from the School Health Policies and Programs Study sponsored by the Centers for Disease Control in 1994 indicate that more than half of all states fund school-based or school-linked health clinics and several states have adopted policies regarding prevention and support around the issue of HIV. The study also found that "despite the expanding role of school health services, there is no clear consensus on the role of the health professionals in the school setting" (cited in Igoe & Duncan, 1996, p. 10).

Also in 1994, the National Association of School Nurses, the American Nurses Association, and the University of Colorado Health Sciences Center, Office of School Health (cited in Igoe & Duncan, 1996) examined school health services and providers in 482 school districts across 45 states. Examining service provision across elementary, middle and high schools, study respondents were school nurse supervisors. Results pertaining to the provision of mental health services suggest that the evaluation of emotional/behavioral problems was a commonly provided service, occurring in 80 percent of surveyed schools. Nearly 60 percent of the school districts offered mental health counseling and many school health personnel reported needing more preparation in this area. Family counseling was offered in 31.8 percent of districts and 83 percent of school districts conducted child abuse evaluations and follow-up. Additional data suggests that two of the five most likely groups to be included on district school health teams were psychologists and counselors, suggesting that many schools recognized the importance of addressing mental health issues for students. Over 55 percent of school districts employed counselors, 40 percent employed psychologists and 21 percent employed social workers. Dryfoos (1995) has suggested that it is possible to find over 40 different types of school personnel working in school-based programs.

Similar to the findings of the Robert Wood Johnson Foundation surveys, the National Association of Nurses (1994) study found that school-based student health centers (SBHCs) have been established in over 600 school systems. Defined as a health center located in a school or on school grounds, SBHCs provide, at a minimum, on-site primary and preventive health care, mental health counseling, health promotion, referral and follow up services for clients (The National Education Consortium, cited in Igoe & Duncan, 1996). Igoe and Duncan assert that role confusion and ambiguity continue to be problematic for school health service providers and that evaluation efforts are needed to measure not only children's well being but also their progress.

Generally speaking, the types of mental health services provided in schools cover a wide range of service beyond the provision of special education services, and are directly or indirectly related to academic success (e.g., social skills curricula, anger management training, and support groups

for a wide variety of issues). While most efforts are informal, the structure for providing services generally falls into one of four major categories: traditional/community based models; the school-based model; the school-linked model; and less frequently, the full service school (Bricklin et al., 1995; Dryfoos, 1995). Each is briefly reviewed here.

In a traditional/community-based model, schools are not directly involved in providing mental health services. They function as supports for children and families who request services. The role of school staff involved with this model is to be knowledgeable about the array of services available in the community and to be able to refer families for services that meet their needs. School staff also participate in mental health assessments conducted by outside agencies, and initiate referrals for assessment and intervention. Some of these referrals may be in conjunction with a special-education assessment for a student. Another role for school staff is to be involved in the development of crisis intervention plans. Staff members who typically perform these functions are school social workers, school psychologists, counselors, nurses and special-education teachers.

In the school-based services model, mental health services are provided on-site, often in the context of a school-based health center. As previously described, such centers are becoming increasingly common, especially in middle and high schools. Services may be organized, delivered, and financed through school systems, or they may be merely delivered at the school site by an outside agency or collaborative of service providers (Bricklin et al., 1995). Services provided vary with the needs of the population, but generally include individual and group counseling, consultation with teachers about classroom accommodations for students with emotional and behavioral difficulties, and prevention and education programs aimed at issues such as the prevention of substance abuse, violence and pregnancy.

In school-linked models of service delivery, schools work with medical, mental-health and social-service agencies to provide services in and near the school. Wang, Haertel, and Walberg (1995) note that school-linked services may be comprehensive, providing families and students with a range of health, mental health and social services; or they may be focused on a specific issue, such as substance abuse or teenage pregnancy and parenting. Central to this model is the collaboration that takes place between the school and other agencies.

The fourth model, full service schools, is envisioned by some as "a seamless institution, a community school with a joint governance structure that allows maximum responsiveness to families and communities and promotes accessibility and continuity for those most in need of services" (Dryfoos, 1995, p. 152). Dryfoos suggests that there are three components to a full service school: 1) quality educational services that are provided by schools (e.g., individualized instruction and parent involvement), 2) services that are provided by the school or community agencies (e.g., comprehensive health education, life planning), and 3) support services provided by community agencies (e.g., individual and family counseling, parent

education and literacy, community policing). Currently, there are several examples of full service schools across the country although as yet, the first three models are more frequently utilized.

Despite a strong interest in the provision of mental health services in schools and the rich variety of services provided to students under the rubric of mental health services, evaluations of the efficacy of mental health service provision in schools are scarce. The fact that there is such diversity suggests that schools are responsive to the needs of the students and families they serve, but it makes efficacy evaluations across programs challenging (GAO, 1993; U.S. Department of Education [US Dept. of Ed.], Office of Educational Research and Improvement [OERI], American Educational Research Association [AERA], 1995). Additional sources of difficulty include limited funds for evaluation, lack of public support for impact evaluations, differing program priorities, poor data quality and data collection problems, ethical dilemmas (e.g., how to choose subjects), and a lack of expertise in evaluation (GAO, 1993). Also, people who have used mental health services may be difficult to locate for participation in evaluations and are more likely than other subjects to drop out of studies. (US Dept. of Ed., OERI, AERA, 1995; Wang et al., 1995). Wang et al. note that when program evaluations are available, they generally do not contain descriptions of the magnitude of effects. Thus, conclusions about the statistical or practical significance of findings are not possible. Lack of consensus about what constitutes "mental health service" is also a factor.

While the evidence is limited, research on the efficacy of supportive services in schools suggests that these types of services are making an impact. For example, Wang et al. (1995) reviewed 44 sources that evaluated outcomes for collaborative, school-linked services (although not all of the programs provided mental health services). The authors found six sources that evaluated "integrative services," their category most closely related to mental health services. The results of these studies show positive changes in student achievement, attendance, behavior problems and dropout rates. The authors found similar results for programs in teen pregnancy prevention and parenting, and substance abuse treatment and prevention - examples of more specific collaborative programs that likely encompass mental health services nonetheless. Similarly, in their review of published evaluations of comprehensive school-linked programs and their own reviews of ten such programs, the GAO (1993) reported that some school-linked human services have an impact on attendance rates and subsequently, dropout rates, rates of pregnancy, academic achievement and incidents of suspension (GAO, 1993). Other research has shown that comprehensive health education curricula has led to improvements in health knowledge, attitudes, and most importantly, behaviors (Chervin & Northrup, 1994).

Overall, it appears that the continuation of supportive services in schools is indicated although much more research is needed to determine exactly what services are being provided to students as well as evaluating

what impact these services are having on student outcomes, both academic and social/emotional.

Federal and state mandates

Cultural and social factors have not operated in a vacuum to influence the way that individual schools respond to the mental health needs of students. Cultural and social forces have also shaped - and been shaped by - laws mandating the provision of education-related mental health services.

Federal and State Mandates

Three federal laws have specifically mandated the provision of education-related mental health services to children with disabilities and their families. These are: Section 504 of the Rehabilitation Act of 1973; the Individuals with Disabilities Education Act (Part B); and the Education of the Handicapped Act Amendments of 1986 (Part H). Because these laws are federal mandates, with compliance monitoring, supporting regulations and case law, they have been powerful influences shaping schools' involvement in mental health service delivery (Yell, 1996). However, the language in these laws regarding mental health services is vague. The laws do not provide school practitioners with concrete definitions of psychological and counseling services. Neither do they offer firm guidelines about how and when these services must be provided as part of the mandated free and appropriate public education (FAPE) for students with disabilities. Furthermore, the laws relate primarily to students with disabilities. They therefore do not describe - or prescribe - the many efforts schools put forth to prevent and ameliorate mental health problems in students who are not classified as disabled.

Section 504 of the Rehabilitation Act of 1973.

The Rehabilitation Act of 1973, the precursor of the 1990 Americans with Disabilities Act, was designed primarily to protect the civil rights of people with disabilities. Section 504 of this act "prohibits discrimination against individuals with disabilities by school districts receiving federal financial assistance" (Minnesota Department of Education, 1994, p. 1). The law requires that students with disabilities have equal access to a free and appropriate public education.

Free appropriate public education, according to a 1977 federal regulation, includes "the provision of regular or special education and related aids and services that...are designed to meet individual educational needs of handicapped persons as adequately as the needs of non-handicapped persons." (emphasis added) (Ysseldyke, Algozzine & Thurlow, 1992, p. 313). Unlike IDEA, Section 504 does not specifically call for particular types of related services. However, regulatory comments describe "psychological counseling" as an example of a related service (Crawford & Zirkel, 1993). The scope and type of psychological counseling services intended by the legislation are not clear. Typically, descriptions of Section 504 accommodations do not

provide details about mental health interventions. However, there are a few references to schools providing social-skills group experiences, individual and group counseling, and referrals to programs for parents (Minnesota Department of Education, 1994, p. 104).

Physical-plant changes, and modifications in classroom structure and process are more typical of the type of accommodations described in documents about Section 504. At first glance, these modifications may seem far removed from traditional notions of mental-health interventions. However, a closer examination indicates otherwise. Physical-plant, classroom-structure, and classroom-process accommodations are designed to accommodate students who have a variety of disabilities, including emotional and behavioral disorders, attention-deficit disorder, and learning disabilities. Furthermore, school psychologists, social workers and counselors in many districts consult with teachers about such modifications (Kratochwill, Elliott & Rotto, 1995; Maag, 1996). Frequently in such consultation, these professionals apply psychological principles to help teachers modify classroom structure and processes for students. Following Rog's (1992) definition of mental health services, this consultation is best conceived as both educational and mental health service. The staff members providing the consultation may see themselves primarily as educators or mental health professionals, or they may view themselves as simultaneously wearing two hats.

Section 504 is different from the better-known Individuals with Disabilities Education Act in a number of key ways. Section 504 is civil-rights law, while IDEA, covering property rights, is education law. Section 504 serves a broader population of students than does IDEA. Students with disabilities who do not require special education services (including students who have exited special education) may be covered by Section 504. In recent years, for example, Section 504 has become a major route for providing educational modifications for students with Attention Deficit Hyperactivity Disorder (Kardon, 1995). However, neither the Federal Office of Civil Rights, nor the Minnesota Department of Children, Families and Learning keeps statistics on the number of students eligible for accommodations under Section 504. This lack of data may present serious problems for school districts attempting to estimate and plan the scope of accommodations and services for students with disabilities.

Another difference between the two laws is that local school districts are entirely responsible for funding the special services and accommodations required by Section 504. Districts cannot use state special education funds to pay for accommodations for students who meet Section 504 criteria but not IDEA criteria. There are no federal funds to provide federally-mandated 504 accommodations. Anecdotal evidence suggests that the lack of funding discourages some schools and districts from providing mental health and other related services to students who do not meet IDEA criteria. IDEA (Part B).

The Individuals with Disabilities Education Act (IDEA).

IDEA (Formerly P.L. 94:142, the Education of the Handicapped Act; revised and retitled in 1990) guarantees a free appropriate public education to all children with disabilities. It specifies that related services must be provided, which are "such developmental, corrective and other supportive services as are required to assist a child to benefit from special education" (Crawford & Zirkel, 1993). Psychological and counseling services, including parent counseling are specifically listed as examples of related services.

Children ages 3-21 are covered by Part B of the act; children ages 0-3 are covered by Part H (described below.) About 98,000 children in Minnesota receive specialized education services under Part B. Most of the children (64 percent) are diagnosed as having learning disabilities, mild to moderate mental retardation or emotional/behavioral disorders (Minnesota Department of Children, Families and Learning, 1996b).

Two thorny definition issues underlie any discussion of schools' roles in providing mental health services under IDEA. The first issue is defining "free appropriate public education" as mandated by the law. The criteria for "appropriate" education are vague; therefore, it can be difficult for educators to judge when a related service is required in order to make a student's education appropriate. The second difficult issue is defining "psychological" and "counseling" services, and determining whether they are educationally or medically necessary, or both.

Definitions of "appropriate education" have been clarified more by court decision more than by state or federal policy. The courts have used several different lines of logic to determine whether specific related services are required to make a student's education appropriate (Turnbull and Turnbull, 1990). In a widely-cited example (Hendrick Hudson District Central School District v. Rowley 1982), the United States Supreme Court described IDEA as giving children with disabilities a "reasonable opportunity" to learn. Congress, the justices believed, "did not intend for the schools to develop students' capacities to their maximum." (Turnbull & Turnbull, 1990, p. 219). Reasonable opportunity under this minimalist standard can be demonstrated by a student's progress, such as passing a grade. The Rowley decision, however, does not prevent states from establishing more stringent standards for appropriate education, and a few such standards have been created and upheld in other courts (Underwood & Mead, 1995).

A cautionary note similar to Rowley was sounded by the U.S. Supreme Court in *Irving Independent School District v. Tatro* (1984). In that case, the court noted that "only those services necessary to aid a handicapped child to benefit from special education must be provided" (Underwood & Mead, 1995, p. 119). However, "necessary" and "benefit" are not any clearer than "appropriate."

Underwood and Mead (1995) suggest three questions for educators to consider in determining whether a particular related service - such as counseling - is a necessary service:

- Is the service necessary for the student to gain access to or remain in the special program?
- Is the service necessary to resolve other needs for the student before educational efforts will be successful?
- Is the service necessary for the student to make meaningful progress on the identified goals [of the Individualized Education Plan]? (p. 117).

Our literature review revealed very similar questions, which probe the vague legislative and legal terms in an attempt to help educators make them specific and useable guidelines for service design.

Defining psychological and counseling services is another key to understanding schools' roles in providing mental health services under IDEA. These services are not defined in the legislation, and the relevant federal regulations are not clear. Counseling services, for instance, are simply described as "services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel" (34 C.F.R. § 300.16(2(2))). Parent counseling and training is defined as "assisting parents in understanding the special needs of their child and providing parents with information about child development" (34 C.F.R. § 300.16(2(6))).

The definition of psychological services is somewhat more specific. This definition "includes administering psychological and educational tests and other assessment procedures; interpreting assessment results; obtaining, integrating and interpreting information about child behavior and conditions relating to learning; consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and planning and maintaining a program of psychological services, including psychological counseling for children and parents." (IDEA Regulations 34 C.F.R. § 300.16(2(8))). Figures for 1986-87 indicated that psychological services comprised a very substantial 42 percent of the related services provided under IDEA (Ysseldyke, Algozzine, & Thurlow, 1992).

In practice, related services that are solely psychological in nature are difficult to identify. Many of these services are intended to provide both psychological and educational benefits to children. Examples are anger-management interventions and social skills groups for disruptive children, dropout-prevention initiatives, and stress-management interventions for children experiencing anxiety or depression. Consultation provided to teachers by mental health professionals on behavior management is particularly difficult to label as solely a mental health or educational service.

Because existing law and public policy remain unclear, the issue of whether psychological and counseling services are required for students with disabilities has often been settled by the courts. Because of the close connection between mental health and educational services, a number of

court decisions have affirmed schools' obligations to provide psychotherapy as a related service that enables a student to benefit from special education. For example, a federal district court held in *North v. District of Columbia Board of Education* (1979) that school districts must provide treatment when a student's medical, social and educational needs "are so intimately intertwined that realistically it is not possible" for the court to separate them (Yell, p. 21). Several other cases have affirmed that counseling and psychological services are not necessarily medical services. (Schools are not required to provide medical services under IDEA). Regarding residential placements, some courts have concluded that psychotherapy and residential treatment must be provided for students with severe emotional disturbances, if these services are deemed educationally necessary. However, other decisions have held that schools are not required to provide residential treatment when it is primarily a medical treatment, or when an appropriate program already exists in the public school. (For a more comprehensive review of these cases, see Yell, 1996.)

The funding of related services remains particularly troublesome for local education agencies. IDEA was originally authorized to be funded by the federal government at 40% of the actual costs. The federal contribution has never exceeded 12%. This discrepancy has resulted in substantial financial burden being placed on state and local funding mechanisms. These services often compete for scarce education dollars that must support a broad array of programs and services.

Special education services, including related psychological services, are funded by a combination of local, state and federal education dollars. Strategies for funding vary from state to state and community to community. This complex system of funding often confounds the policy surrounding service delivery. Several efforts have been undertaken to strengthen funding for special education. Turnbull and Turnbull (1990) say that in 1988, Congress amended the Social Security Act in such a way as to allow schools to bill state Medicaid funds for services that are reimbursable under the state's Medicaid plan, for students whose Individualized Education Plan calls for those services. Many states have taken full advantage of such strategies resulting in substantial funds being drawn down. Minnesota has taken a more conservative approach regarding third party billing for special education services.

Concerns about costs and funding for mental health services leads some educators to shy away from including them in a student's IEP. As Maag (1996) notes, "We find it difficult to imagine a child receiving the EBD label for whom psychotherapy would not be appropriate and have some either direct or residual benefit to the child's education. Yet...counseling as a related service is rarely included in the IEP's of children with EBD" (p. 13). Knitzer, Steinberg and Fleisch (1990) echo this assertion, noting that there are no data on how many students with EBD nationwide have IEP's that specifically include psychological or counseling services. Within individual districts, "whether or not students [with emotional and behavioral disabilities] have

access to mental health services varies enormously, and that if they do, it is either very short-term or parents pay for it" (p. xii). Minnesota's most recent federal monitoring of special education services cited the state for not assuring that counseling services were available, especially to students with emotional and behavioral disorders.

It should be noted that IDEA is currently undergoing congressional reauthorization. Some drafts of the revised legislation that have been put forward during the past year have made significant changes in the federal mandate to provide related services; others have left these sections of the law relatively untouched. What the federal mandate for related services will look like in the future is unclear at this time.

Public Law 99-457 (Part H), The Education of the Handicapped Act Amendments of 1986.

Part H is different from Part B of IDEA specifically in that it mandates interagency coordination in the provision of services for children from birth to age 3. Among other things, it authorized funds for states to "develop and implement a comprehensive, coordinated, multidisciplinary, interagency program of early intervention service" (Martner & Magrab, 1989, p. 10).

When Congress enacted P.L. 99-457, there was little connection between mental health services and early intervention. This law "opens the door" for mental health professionals to provide services for infants, toddlers with - or at risk for - psychosocial delays (Martner & Magrab, 1989, p. 2). Mental health services that are provided to children and families under this act include counseling and home visits, family training, and psychological assessment and intervention. Psychologists are among the "qualified personnel" who may provide early intervention services (Larson, 1983, p. 5).

Part H is distinct from other programs in that it does not mandate the development of any particular new service; it is designed to foster the coordination and development of current programs and systems. Federal funds were made available to states for five years as they brought existing local agencies into collaborative relationships (Minnesota Department of Children, Families and Learning, 1996). In 1993, approximately 2,400 Minnesota children and families received early intervention services under the Part H umbrella. Schools are key local agencies in providing early intervention services to children and families: In Minnesota, the State Department of Education was the lead agency charged with overseeing the implementation of Part H plans, before that agency merged into the Department of Children, Families and Learning. State mandates.

Outside of education, most states have established legislation directing the provision of mental health services to children. While these laws aren't directed solely at schools, the language is clear that schools are meant to be part of the effort. The Minnesota Comprehensive Children's Mental Health Act is an example of this type of legislation. In fact, Minnesota is one of only a handful of states whose legislature created an interagency organization at

both the local and state level to coordinate a system of care, and established a regional system for coordinating the delivery of those services across agencies. Minnesota's law, however, does not mandate that the agencies pool resources; only a very few states have taken that step. (Davis, Yealton & Katz-Leavy, 1995).

The Minnesota Comprehensive Children's Mental Health Act.

This act, passed in 1989 (Minnesota Statutes 245.487-245.4887) does not focus strongly on schools as mental health service providers, but the language is clear that schools are meant to be part of an interagency network serving children with severe emotional disturbances. The act is based on philosophy of the Child and Adolescent Service System Program (CASSP), which was developed by the National Institute of Mental Health. CASSP has served as a model for many state efforts to improve children's mental-health services.

The Minnesota law directs the commissioner of human services to:

- identify and treat the mental health needs of children in the least restrictive setting;
- provide mental health services to children and their families in the context in which the children live and go to school;
- maintain a local coordinating council "representing all members of the local system of care including mental health services, social services, correctional services, education services, health services and vocational services." (M.S. 245.487-4887)

A state task-force report on the Children's Mental Health Integrated Fund (Minnesota Department of Human Services, 1992) described a disorganized patchwork of services for children with emotional and behavioral disorders. Federal, state and local education dollars constitute the largest segment of funding available for these children and their families, but it's not clear how schools were meant to work with other agencies to provide services, the authors note. When related services are required under IDEA for a child with EBD, "it is unclear which agency is supposed to take the lead role" (p. 21). At a policy level, it is not at all clear how IDEA and the Children's Mental Health Act are meant to work in concert to provide children's mental health services.

Conclusions and Recommendations

A large body of literature consistently demonstrates that children and youth have many mental health needs that are unmet by the current service systems. Recognizing that mental health, social development and educational success are inextricably linked, schools have historically provided a variety of formal and informal mental health services to children. Efforts to

provide children and youth with the mental health services they need vary widely in rigor and scope.

The active involvement of schools in mental health services stems from a variety of influences, including, but not limited to, societal shifts, federal and state mandates, and locally pressing need for such services. However, education's role in providing mental health services has evolved largely in the absence of comprehensive policies regarding mental health services in education. The vast majority of the mental health effort is relegated to informal organizational structures that are not supported by formal policy. This has resulted in a system of services that is poorly articulated, with little formal accounting of expenditures and little outcome data on which to base program or policy decisions.

The lack of comprehensive policies presents problems for educators - and for children and families. Without policies encouraging collaboration, services have become fragmented, reactive and inaccessible to the consumers who need them. In such an atmosphere, it has been difficult for educators and mental health professionals to determine exactly when, how and by whom mental health services should be provided. It is equally difficult to establish accountability and to assure continuity of services when roles are so poorly defined.

There is a lack of consensus regarding education's role in mental health. Educators in general have yet to formally engage in a debate concerning the merits and challenges of addressing the mental health needs of learners. This is despite an extensive body of literature articulating the implications of mental health problems for learners and for society. Children identified as having emotional and behavioral disorders have the poorest outcomes of any group of students served by special education. These students are beyond risk for school failure. As a group, they have the highest drop-out/push-out rate, are the most likely to fail classes, the least likely to be gainfully employed after high school, and the most likely to be involved with the criminal justice system. Beyond the students in special education populations, the unmet mental health needs of students in general education are consistently well documented in reports of child and adolescent health. The result is that for many in this expanding group of learners, high standards and rigorous outcomes become unreachable and irrelevant.

President George Bush often referred to "points of light" when describing the many promising efforts to improve life for the citizens of this country. Efforts to provide mental health services to children and youth have provided little beyond flashes of light; all too often such efforts have not been sustainable for a host of economic and political reasons. Current efforts to promote systems change through the development of formal collaborative interagency service structures shows great promise. However, children's mental health services have received only modest attention and financial support from policy makers at the state and local level. In many respects, it is a shameful picture that has been portrayed by report after report on the state of our children's mental health service system.

To remedy this situation, the concerted efforts of policy makers at all levels of government will be needed. This will likely be an expensive endeavor, yet we must come to clearly understand the very real costs of not attending to mental health needs of our children and youth. Systems change in an environment of shrinking resources will be difficult at best. Yet, mental health needs will not be denied their due.

The following set of recommendations represent a distillation of the literature reviewed here and the thoughts of the authors. These points are offered as considerations in the development of policy and practice in addressing, in educational contexts, the mental health needs of our children and youth.

- There currently exist efficient and effective models for the delivery of children's mental health services, including school-linked, school-based and full service schools.
- All state departments entrusted with programs affecting children need to have available, as a formal part of the organizational structure, persons and programs that can competently address policy concerns regarding children's mental health.
- State departments and local service system providers must develop strong policy that is respectful of families and clearly defines the roles and responsibilities of the service system. The education community must develop state and local policy that clearly defines mental health services in a manner consistent with existing law.
- Champions of children's mental health need to be identified and supported in state and local education policy arenas. Expertise in mental health promotion and intervention must continue to be developed and utilized in the development of policy.
- Substantial training is needed to raise awareness of the importance of mental health. A public relations campaign must be mounted to confront the stigma of mental illness and the resulting discrimination. Staff working in state and local education systems need access to ongoing training opportunities to assure that interventions, programs and policies support healthy emotional development for all children.
- Funding for education and other mental health services must be dramatically increased if communities are to be afforded a reasonable opportunity to overcome the mental health challenges children face.
- The mechanisms for funding services must be simplified and made public so that programmatic decisions can be based on data from the

total system of care. Programmatic decisions must be fiscally responsible to the total system of care and be independent of simple cost-shifting between members of the service system.

- Families must be assured of their right to direct the care of their children. Policies and the resultant services must be sensitive to the diversity within a particular community.
- Approaches to the provision of mental health services must be comprehensive and involve the total community. Education must be a full partner in any community effort.

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